



# UnitedHealthcare Community & State

Hoosier Care Connect Health Plan

Behavioral Health

Presented by David Hoover, Senior Provider Relations Advocate

United  
Healthcare®

# Agenda

- **Contacts**
- **Enrollment**
- **Attestation**
- **Prior Authorization**
- **CommunityCare**
- **Claims**
- **Telehealth**



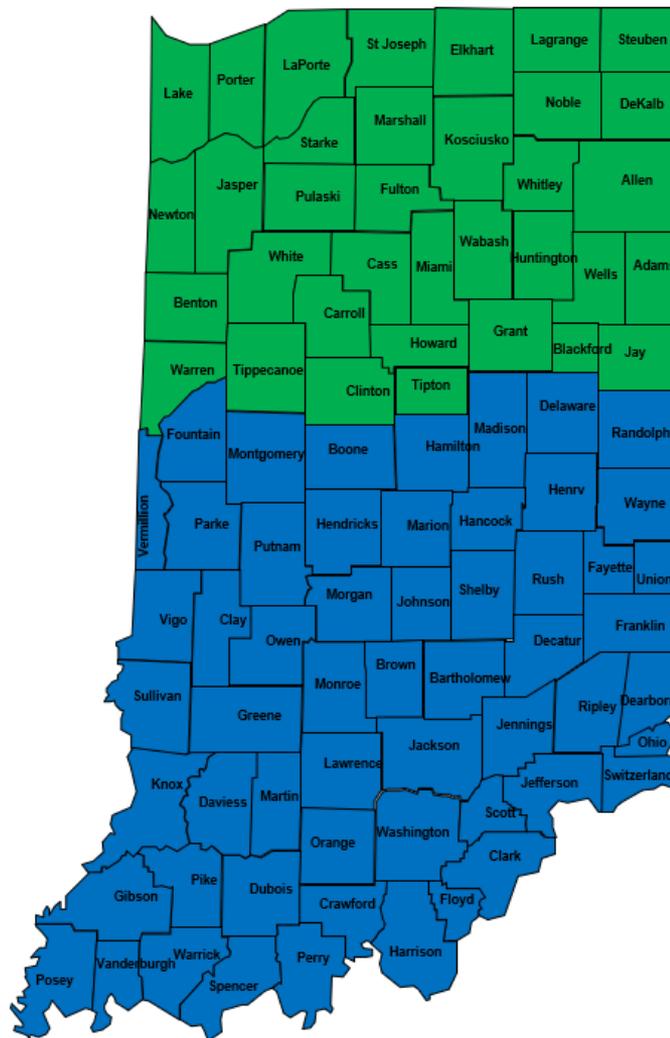
# Provider Advocates

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TBD

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# Optum Behavioral Health Network Providers

Behavioral Health Network providers include:

- Board Certified Behavior Analyst
- Clinical Nurse Specialist
- CRS – Prescriptive Authority
- Doctor of Osteopathic Medicine
- Health Service Provider in Psychology
- Licensed Clinical Addiction Counselor
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Mental Health Counselor
- Medical Doctor
- Nurse Practitioner
- Physician Assistant
- Registered Nurse
- Community Mental Health Centers
- Rural Health Clinics
- Federally Qualified Health Centers
- Substance Use Disorder Agencies
- Inpatient Facilities



# Provider Enrollment – Individual Providers

- Individually contracted Behavioral Health clinicians apply via the United Healthcare website at [UnitedHealthcare Community Plan of Indiana Homepage | UHCprovider.com](https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home.html)

UnitedHealthcare Community Plan of Indiana Homepage

Bulletins and Newsletters

Care Provider Manuals

Claims and Payments | UnitedHealthcare Community Plan of Indiana

Eligibility and Benefits

How to Join the UnitedHealthcare network

Pharmacy Resources and Physician Administered Drugs | UnitedHealthcare Community Plan of Indiana

**Welcome to the Home for Care Provider Resources**

For UnitedHealthcare Community Plan of Indiana

**UnitedHealthcare Community Plan of Indiana Homepage**

We know you don't have time to spare, so we put all the UnitedHealthcare Community Plan resources you need in one place. Use the navigation on the left to quickly find what you're looking for. Be sure to check back frequently for updates.

**Prior Authorization and Notification Resources**

**Learn More**

**Current Policies and Clinical Guidelines**

**Learn More**

**Provider Administrative Manual and Guides**

**Learn More**

**Prior Authorization and Notification Resources**

**Learn More**

**Current Policies and Clinical Guidelines**

**Learn More**

**Provider Administrative Manual and Guides**

**Learn More**

Expand All

**Contact Us**

**Join Our Network**

**Medicaid Managed Care Rule**

**Member Information: Current Medical Plans, ID Cards, Provider Directories, Dental & Vision Plans**

**Network Management and Provider Relations**

**PCP Membership Reports**



# Provider Enrollment – Individual Providers

## How to Join the UnitedHealthcare network

UnitedHealthcare Community Plan of Indiana Homepage

Bulletins and Newsletters

Care Provider Manuals

Claims and Payments | UnitedHealthcare Community Plan of Indiana

Eligibility and Benefits

How to Join the UnitedHealthcare network

Pharmacy Resources and Physician Administered Drugs | UnitedHealthcare Community Plan of Indiana

Policies and Clinical Guidelines

Prior Authorization and Notification

Provider Forms and References | UnitedHealthcare Community Plan of Indiana

Training and Education | UnitedHealthcare Community Plan of Indiana

Other Resources | UnitedHealthcare Community Plan of Indiana

UnitedHealthcare Dual Complete® Special Needs Plans

### How to Join the UnitedHealthcare network

Become part of the UnitedHealthcare Community Plan of Indiana Hoosier Care Connect network. You'll join a group of physicians, health care professionals and facilities who share our commitment to helping people live healthier lives and making the health care system better for everyone. Review the following instructions and requirements for your medical specialty.

**Please note:** You will be notified if your request to join the network (referred to as your network participation request) is not complete. Notification will be sent within 5 business days after we receive your initial request. The notification will confirm if your network participation request is complete or if we need additional information. Below are the most common reasons a network participation request is considered incomplete:

Category	Issue(s)	Requirement
CAQH	<ul style="list-style-type: none"> <li>Your CAQH profile status is incomplete or expired.</li> <li>We do not have authorization to access your CAQH application. Log into the CAQH ProView Provider portal, go to the user account setting menu and review the Authorization section to update your preferences. Be sure to authorize UnitedHealthcare.</li> <li>Information in your completed CAQH profile needs to be updated (Examples include practice information, credentialing contact information, license and professional liability insurance effective and expiration dates)</li> </ul>	The information on CAQH must match the information you provide on your network participation request
Attached Documents	<ul style="list-style-type: none"> <li>Attaching the wrong document</li> <li>Not signing the W-9 form or providing an incorrect Tax ID number</li> </ul>	Providing all the correct and completed documents is required.
Document Return	<ul style="list-style-type: none"> <li>Slow response time to requested information</li> </ul>	Missing documents are signed and returned as quickly as possible.

Health care professionals (excluding specialists listed below) ▾

Hospitals and healthcare facilities ▾

Ancillary Facilities ▾

**Behavioral health** ▾

Physical Health ▾

Dental Providers ▾

Vision ▾

Skilled Nursing Facilities ▾



# Provider Enrollment – Individual Providers

## To begin the process

This section applies to behavioral health practitioners, ABA providers and facilities. If you work in this specialty area, the process to join our network begins with Optum Behavioral Health. They handle credentialing and contracting on behalf of UnitedHealthcare.

To start the network participation request process, go to Optum's [Join Our Network](#) page and click on the button associated with your provider type (e.g., Individual Clinician, Agency, Facility, Autism/ABA).

- Please complete all fields and submit all applicable information
- Make sure all CAQH information is current and attested
- Ensure all requested documents are current and accurate
- Review the [Optum Provider Express Onboarding Process](#) for additional details

You must also be enrolled with Indiana Health Coverage Programs (IHCP). If you haven't already done so, complete your [provider enrollment](#).

A complete request to join the Optum Behavioral Health network must include:

- Active Medicaid ID obtained through IHCP
- Current CAQH application, with access granted to UnitedHealthcare
- National provider identification (NPI) number
- W-9
- Phone & fax number
- Email address
- Physical address, including suite number if applicable
- ZIP code + 4

## Here's what happens next

Optum Behavioral Health will quickly review your application. Within 5 business days, they'll notify you by mail or email if your request is complete or if they need additional information from you (see the list above outlining what must be included for a request to be considered complete).

## How to check the status of a network participation request

If you have questions about the status of an Optum Behavioral Health request for network participation, call 877-614-0484. Please provide your One Healthcare ID for clinicians or your Provider Reference Number for agencies or facilities (provided at time of submission of your request for network participation) to facilitate checking status of your request.

For individual practitioners, you can also use your One Healthcare ID to check status throughout the network participation request process using the Initial Credentialing Toolbar on the Provider Express [website](#).

## Questions?

If you have questions, call Optum Behavioral Health Solutions at 877-614-0484.



# Enrollment options

[Home](#)[Our Network](#)[Clinical Resources](#)[Admin Resources](#)[Video Channel](#)[Training](#)[About Us](#)[Contact Us](#)[Optum - Provider Express Home](#) > [Our Network](#)

## Our Network

[Click here for state-specific information](#)

### Autism/ABA/BCBA Providers

Optum is recruiting Board Certified Behavior Analysts (BCBA) in solo private practice and qualified agencies that provide intensive ABA services in the treatment of ASD, for our Autism/ABA provider network.

[Click here to join](#)

### Individually-Contracted Clinicians

To apply as an individual, you must be a solo clinician or practicing within a group that does not currently have a group agreement with Optum.

[Click here to join](#)

### Facility or Hospital-Based

To apply for Facility or Hospital-Based, your facility must offer MH or SUD Inpatient, Residential, Partial Hospitalization or Intensive Outpatient Levels of Care.

[Click here to join](#)

### Group with Individually Credentialed Providers

To apply for group with individual credentialing, you must be part of a group that has a group agreement with Optum.

[Click here to join](#)

### Group with Agency Credentialed Providers

To apply for Agency credentialing, your group must be designated as a Community Mental Health Center (CMHC), Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Opioid Treatment Program (OTP), and/or other Federally or State licensed or certified entity (license or certification is at the organizational level).

[Click here to join](#)

### Learn more about our Specialty Network Requests

[Express Access](#)

[virtual visits](#)



## Individually Contracted Clinicians

To verify the provider's license meets the qualifications to Join Our Network, please check [License](#) 

CAQH Participation is required in the majority of the states to join our network. If your state requires it, you will be required to enter your CAQH ID # on the credentialing application. To participate in CAQH, please contact: [www.CAQH.org](http://www.CAQH.org)

### Improve the Speed of Processing - Tips for Applying to the Network

We recently conducted an audit of credentialing application issues. Here's an at-a-glance view of the most common issues that will slow down or lead to the cancellation of the credentialing of your application to join our network.

Category	Issues	Requirement
CAQH	<ul style="list-style-type: none"><li>Your CAQH profile status is incomplete or expired</li><li>Your group information including but not limited to primary and practice locations listed on your UBH Network Participation form does not match what you have listed on your CAQH profile</li><li>We do not have authorization to access your CAQH application (log into the CAQH ProView Provider portal, go to the user account setting menu and review the Authorization section to update your preferences to authorize United Behavioral Health/US Behavioral Health Plan)</li><li>Information in your completed CAQH profile needs to be updated (Examples include Practice Information, Credentialing Contact information, License and Professional Liability Insurance effective and expiration dates)</li></ul>	The information on CAQH must match the information you provide on the Optum NPRF form.
Attached Documents	<ul style="list-style-type: none"><li>Attaching the wrong document</li><li>Not signing the W-9 form or providing an incorrect Tax ID number or EIN</li><li>Current Professional Liability Insurance Certificate</li></ul>	Providing all the correct and completed documents is required.
Document Return	Slow response time to requested information. <ul style="list-style-type: none"><li>Individual Contracts</li><li>Disclosure of Ownership documents</li></ul>	Missing documents are sent out via DocuSign. Sign and return as quickly as possible.

#### Continue

After clicking the Continue button you will be prompted to register or login to Provider Express. Once you are logged in to Provider Express, please use the Join Our Network feature in the menu to proceed to the credentialing application.

For help with this process: [Registering a Provider Access and Starting the Online Optum Credentialing Application](#)  

Individual providers – Login to Provider Express and use the Check Initial Credentialing Status under the My Network Status feature in the menu

# Provider Enrollment – Individual Providers

• Individually Contracted Clinicians: To apply as an individual, you must be a solo clinician or practicing within a group that does not currently have a group agreement with Optum.

<https://www.providerexpress.com/content/pe-provexpr/us/en/our-network/individually-contracted-clinicians.html>



# Applied Behavioral Analysis (ABA)

## Individual Board Certified Behavior Analysts – Solo Practitioner

- Board Certified Behavior Analyst (BCBA) requires a master's degree in psychology or behavior analysis with active certification from the national Behavior Analyst Certification Board, **and**
- Medicaid ID
- Compliance with all state autism mandate requirements, as applicable to behavior analysts
- A minimum of six months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Minimum professional liability coverage of \$1 million per occurrence / \$1 million aggregate

## ABA / IBT Groups

- BCBA must meet standards above and hold Supervisory Certification from the national Behavior Analyst Certification Board if in supervisory role
- Compliance with all state/autism mandate requirements as applicable to behavior analysts/ABA practices
- BCaBAs required to possess an undergraduate degree and must have active certification from the national Behavior Analyst Certification Board
- Behavior Technicians must be a high school graduate and receive appropriate training and supervision by BCBA
- BCBA on staff providing program oversight
- BCBA performs skills assessments and provides direct supervision of BCaBAs/Behavior Technicians in joint sessions with client and family
- \$1 million/occurrence and \$3 million/aggregate of professional liability and \$1m/\$1m of general liability if services are provided in a clinic setting
- \$1million/occurrence and \$3million/aggregate of professional liability and \$1m/\$1m of supplemental insurance if the agency provides ambulatory services only (in the patient's home)



# Agency Enrollment

Group with Agency Credentialed Providers: To apply for Agency credentialing, your group must be designated as a Community Mental Health Center (CMHC), Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Opioid Treatment Program (OTP), and/or other Federally or State licensed or certified entity (license or certification is at the organizational level).

- <https://www.providerexpress.com/content/ope-provexpr/us/en/our-network/Group-with-agency-credentialed-providers.html>



## Group with agency credentialed providers



In order to apply for Agency credentialing, your group must be designated as a Community Mental Health Center (CMHC), Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Opioid Treatment Program (OTP), and/or other Federally or State licensed or certified entity (license or certification is at the organizational level).

Your organization must have the minimum Liability insurance of \$1 million/ \$3 Million for both General Liability and Professional Liability.

If you meet these requirements, [click here to complete the Agency application](#).

For questions or help – *contact Network Management at (877) 614-0484*

If your Agency only provides ABA services, [click here to complete the Autism/ABA/BCBA application](#).

Please note that the following documents will be required (as applicable):

- A current state license or certificate for all services and locations where you offer services
- Optum accepts the below accreditations. If you are not accredited, a site audit will be required before the credentialing process will be complete
  - Accreditation Association for Ambulatory Health Care (AAAHC)
  - Accreditation Commission for Health Care, Inc. (ACHC)
  - Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Community Health Accreditation Program (CHAP)
  - Center for Improvement in Healthcare Quality (CIHQ)
  - Det Norske Veritas National Integrated Accreditation for Healthcare Organizations (DNV NIAHO)
  - Healthcare Facilities Accreditation Program (HFAP)
  - Joint Commission (TJC)
  - Council on Accreditation (COA)
- Medicaid and/or Medicare certification letters with applicable registration numbers
- Current Professional and General Liability insurance certificates showing limits, policy number(s) and expiration date(s)
- W9 form
- Current Staff roster including license, taxonomy and NPI
- For Opioid Treatment Programs (OTP), copies of the prescribers' DEA licenses are required



# Facility or Hospital Enrollment

Facility or Hospital-Based groups: For Facility or Hospital-Based enrollments, your facility must offer MH Inpatient, Residential, Partial Hospitalization or Intensive Outpatient Levels of Care.

- <https://www.providerexpress.com/content/ope-provexpr/us/en/our-network/facility-or-hospital.html>



## Facility or Hospital-Based Providers



### Facility or Hospital-Based Providers

- Do you offer licensed/certified Mental Health and/or Substance Use Disorder (SUD) inpatient and/or lower level of care services (i.e., Inpatient, Detox, Residential, Partial Hospitalization (PHP), and Intensive Outpatient (IOP) programs)?
- Do you have minimum professional liability coverage of \$5 million/\$5 million for acute inpatient services, and minimum professional and comprehensive liability coverage of \$1 million/\$3 million for non-acute inpatient services (unless state requirements vary)?

If meet above requirements, please click on the Facility Application link below to complete and select all applicable Level(s) of Care you provide.

**IMPORTANT:** For covered facility-based services billed with Revenue Code or Revenue Code + HCPC or CPT code on a UB-04 form, please complete the Facility Application. For covered facility-based services billed with single HCPC code or HCPC code + CPT code on a CMS 1500 form, please confirm the appropriate application to complete before completing the Facility Application.

[Facility Application](#) 

For questions or help – contact Network Management at (877) 614-0484

#### Please note following documents will be required (As Applicable):

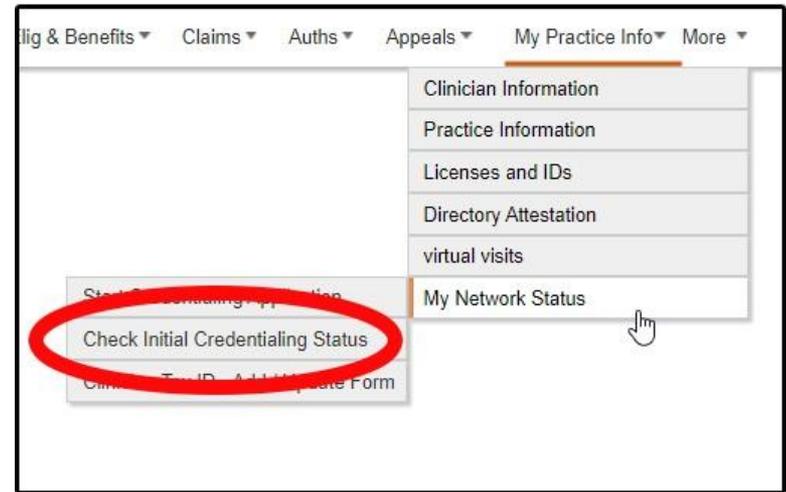
- Current State License(s)/ Certificate(s) for all behavioral health services you provide, i.e. psychiatric, substance abuse, residential, intensive outpatient, etc. A18 – include all documentation for multiple facility locations.
- Accreditation status (i.e. The Joint Commission, CARF, COA, etc.)
- ASAM CARF Level of Care Certification, if applicable
- Medicare or Medicaid certification letter with Medicare number (REQUIRED if applying for participation in Medicaid or Medicare networks)
- Program Description-including any specialty program descriptions and hours per day/ days per week
- Copy of completed Ownership & Disclosure Form (REQUIRED if applying for participation in Medicaid networks)
- Copy of completed Ownership & Disclosure Form (REQUIRED if applying for participation in Medicaid networks)
- Current Professional and General Liability insurance certificates showing limits, policy number(s) and expiration date(s). If self-insured, attach a copy of an independently audited financial statement which shows retention of the required amounts.
- W9 form: If multiple tax ID numbers used, one W9 must be submitted for each (NOTE: required if adding or changing tax ID or entity name)
- Staff Roster for all behavioral health staff involved with your programs. Please list their degrees, licenses and/or certificates. We do not need an actual copy of their licenses or certifications.
- Daily Program Schedule(s) – include an hour-by-hour schedule showing a patient's daily treatment for each level of care you provide. Include weekend scheduling, where appropriate.
- Policy and Procedure on Intake/Access Process to Behavioral Medicine
- Policy and Procedure on Intake/Access Process if done through E.R.
- Policy and Procedure on Holds/Restraints
- Policy and Procedure for Discharge Planning



# Checking Status – Practitioner Initial Credentialing

**Practitioners** – Using the **Initial Credentialing Status Toolbar** you can easily track the status of your online submission as it moves along the approval process. Log into the secure transactions area of Provider Express, hover over *My Practice Info >> My Network Status >>* click on *Check Initial Credentialing Status*.

**Agency or Group Practice, or Facility** – contact Network Management at (877) 614-0484.

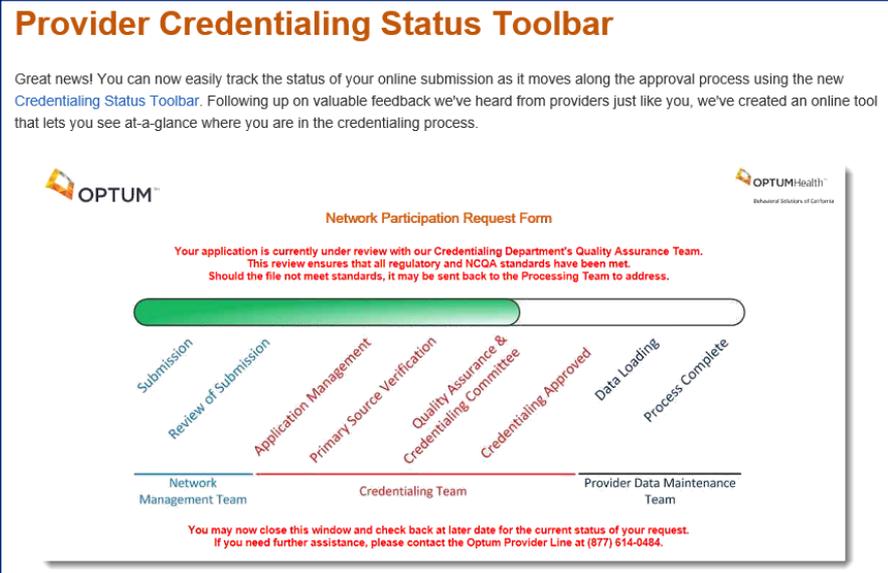


# Practitioner Credentialing Tips

- Ensure your CAQH is accurate and up to date.
- Missing documents from Optum can be submitted via DocuSign. Sign and return as quickly as possible.
- Check the status of your application with the Credentialing Status Toolbar that is available at [Indiana - Provider Express](#).

## Provider Credentialing Status Toolbar

Great news! You can now easily track the status of your online submission as it moves along the approval process using the new [Credentialing Status Toolbar](#). Following up on valuable feedback we've heard from providers just like you, we've created an online tool that lets you see at-a-glance where you are in the credentialing process.



The screenshot displays the 'Provider Credentialing Status Toolbar' interface. At the top, it features the 'OPTUM' logo on the left and the 'OPTUMHealth Behavioral Solutions of Indiana' logo on the right. The main heading is 'Network Participation Request Form'. Below this, a red text block states: 'Your application is currently under review with our Credentialing Department's Quality Assurance Team. This review ensures that all regulatory and NCOA standards have been met. Should the file not meet standards, it may be sent back to the Processing Team to address.' A progress bar is shown with a green segment on the left, indicating the current stage. The process steps are: Submission, Review of Submission, Application Management, Primary Source Verification, Quality Assurance & Credentialing Committee, Credentialing Approved, Data Loading, and Process Complete. Below the progress bar, three teams are listed: Network Management Team (covering Submission and Review of Submission), Credentialing Team (covering Application Management, Primary Source Verification, and Quality Assurance & Credentialing Committee), and Provider Data Maintenance Team (covering Data Loading and Process Complete). At the bottom, a red text block reads: 'You may now close this window and check back at later date for the current status of your request. If you need further assistance, please contact the Optum Provider Line at (877) 614-0484.'



# Attestation

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Why is attestation so important?

- Ensures that provider information is current and accurate
- Allows opportunity to expand on areas of expertise to help grow patient volume
- Keeps providers and groups current on our directory
- Improves triennial re-credentialing cycle efficiency



# How do I determine if a Behavioral Health Service requires Prior Authorization?

\*Most outpatient Behavioral Health services do NOT require an authorization.

- Call the number on the back of the member's card to determine if authorization is required.

- Or -

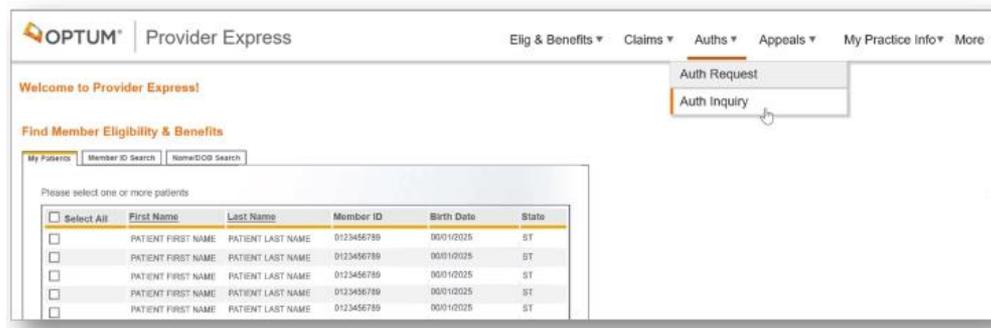
- [Provider Express - Indiana Medicaid](#)

The screenshot shows the Optum Provider Express website. At the top, there is a navigation bar with links for Home, Our Network, Clinical Resources, Admin Resources, Video Channel, Training, About Us, and Contact Us. Below the navigation bar, there is a search bar and a search button. The main content area is titled "Welcome to the Optum Network!" and contains several sections: "Optum Network Manual" with a link to "Network Manual"; "Best Practice Guidelines" with a link to "BP Guidelines"; "Autism/Applied Behavior Analysis" with a link to "Indiana Medicaid ABA Program"; "InterQual Level of Care Guidelines are used and criteria can be provided upon request for specific cases."; "ASAM Level of Care Guidelines are used for Substance Use Disorder (SUD)."; and "Additional information and forms are available, including psych/neuropsych testing guidelines, credentialing plans, and Disability Solutions Manual, on the Provider Express Guidelines/Policies & Manuals and Optum Forms pages." On the right side, there is a section titled "Indiana Medicaid-Specific Resources" with three expandable menu items: "Provider Communications and General Resources", "Claims", and "Prior Authorization and Appeals". The "Prior Authorization and Appeals" menu is expanded, showing a box with text: "For BH prior authorization, please submit the Universal PA form to 844-897-6514." Below this text is a list of links: "Universal Prior Authorization Form", "Substance Use Disorder (SUD) Universal Prior Authorization Form", "IHCP SUD Admission Assessment Form", "IHCP SUD Reassessment Form", "Psych-Neuropsych Prior Authorization Request Form", and "UNITED HEALTHCARE COMMUNITY PLAN OF INDIANA HOOSIER CARE CONNECT BEHAVIORAL HEALTH PRIOR AUTHORIZATION LISTS". A blue arrow points to the last link. Below the list is a link for appeals information: "uhcprovider.com/indiana".



# How do I request Behavioral Health Prior Authorization

- Initiate phone authorization process by calling the number on the back of the member's ID card.
- Securely login to Provider Express and select "Auth Request" from the "Auths" dropdown box.
  - To check on status, select "Auth Inquiry"
- Utilize paper Universal Prior Authorization Form from [Provider Express - Indiana Medicaid](#) and clicking "Prior Authorizations and Appeals".
  - Fax to 844-897-6514



## ▼ Prior Authorizations and Appeals

For BH prior authorization, please submit the Universal PA form to 844-897-6514.

- [Universal Prior Authorization Form](#)
- [Substance Use Disorder \(SUD\) Universal Prior Authorization Form](#)
- [IHCP SUD Admission Assessment Form](#)
- [IHCP SUD Reassessment Form](#)
- [Psych-Neuropsych Prior Authorization Request Form](#)

For appeals information: [uhcprovider.com/Indiana](http://uhcprovider.com/Indiana)



# How do I request Prior Authorization for ABA Therapy Services?

**OPTUM**® Provider Express

[Log In](#) | [First-time User](#) | [Global](#) | [Site Map](#)

Search:

Home Our Network Clinical Resources Admin Resources Video Channel Training About Us Contact Us

[Optum - Provider Express Home](#) > [Our Network](#) > [State-Specific Provider Information](#) > Welcome Indiana

## Welcome to the Optum Network!

Optum Network Manual

- [Network Manual](#)

Best Practice Guidelines

- [BP Guidelines](#)

Autism/Applied Behavior Analysis

- [Indiana Medicaid ABA Program](#)

InterQual Level of Care Guidelines are used and criteria can be provided upon request for specific cases.

ASAM Level of Care Guidelines are used for Substance Use Disorder (SUD).

Additional information and forms are available, including psych/neuropsych testing guidelines, credentialing plans, and Disability Solutions Manual, on the Provider Express [Guidelines/Policies & Manuals](#) and [Optum Forms](#) pages.

### Indiana Medicaid-Specific Resources

- Provider Communications and General Resources
- Claims
- Prior Authorization and Appeals
- Training Resources
- Contacts

**OPTUM**® Provider Express

Home Our Network Clinical Resources Admin Resources Video Channel Training

[Optum - Provider Express Home](#) > [Clinical Resources](#) > [Autism/Applied Behavior Analysis](#) > Indiana Medicaid ABA Program

## Indiana Medicaid ABA Program

Optum is excited to announce that **UnitedHealthcare Community Plan of Indiana** has been awarded a contract to service the Indiana. Optum has been selected by UnitedHealthcare Community Plan to develop and manage the ABA network for Indiana network helps to ensure access to comprehensive quality care for covered behavioral health services for enrolled members.

- [Indiana Medicaid ABA Provider Orientation](#)
- [Indiana Medicaid ABA Quick Reference Guide](#)
- [ABA Treatment Request Form](#)
- [ABA Treatment Request Form](#) (Electronic Submission)

**Contact Us/Request to Join the Network**

Nacole Thompson  
Specialty Network Manager  
[nacole.thompson@optum.com](mailto:nacole.thompson@optum.com)



# How to appeal an Authorization decision?

Include complete record for appeal of authorization decision.

- Member info (name, DOB, RID)
- PA Request
- Denial letter
- Any additional supporting documentation

## **National Appeals Team**

Attn: Appeals

Department/Retrospective Review

P.O. Box 30512

Salt Lake City, UT 84130-0512

Fax: (855) 312-1470

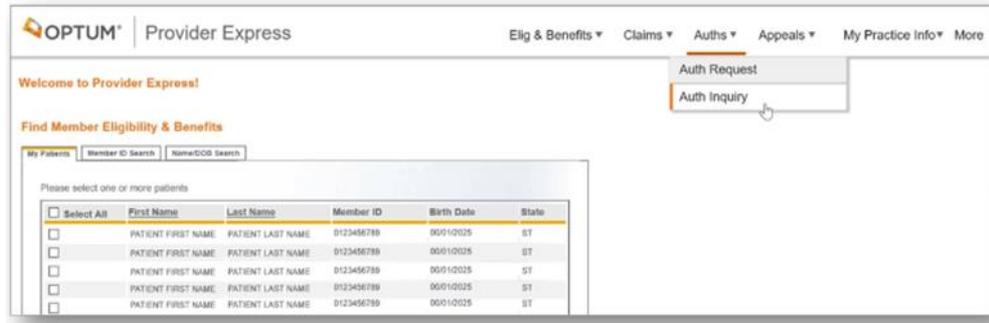
Phone Number: (866) 556-8166



# When you should escalate to your Provider Advocate

If you have not heard back regarding submission of an authorization request:

- Check the Provider Express portal.
- Call the number on the back of the member's ID card.



# How to use CommunityCare to benefit your practice and the member?

We ask that within 5 days of initial visit, please upload member diagnosis, medication list, treatment plan, and any other pertinent information.

- Our Care Management team then reviews what is uploaded within CommunityCare and helps ensure the member gets any and all necessary treatment.
- Providers can verify Emergency Department and Inpatient discharge dates to help assist with getting your patients back into your office in a timely manner to help avoid relapse or other potentially dangerous scenarios.
- CommunityCare can provide insight into quality measures.



# How to file Behavioral claims

- Submit claims using the CMS-1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate.
- Standard Timely Filing for Par Providers - 90 days from the date of service (DOS).
- Non-Contracted Providers Timely Filing – 180 calendar days from DOS.
- Newborn Claims Timely Filing – 180 days from DOS.
- Secondary Claims Timely Filing – 90 calendar days from date of Primary Explanation of benefits for In-network Providers & 180 for Out-of-network providers from the Primary EOB date.



- For electronic submission:  
Payer ID 87726

- Claims Mailing Address:



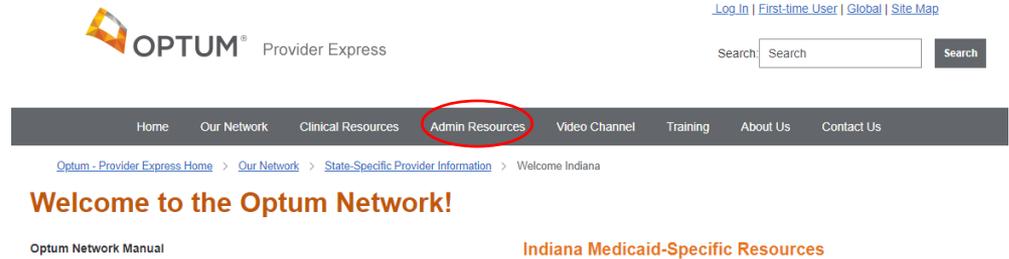
**UnitedHealthcare Community Plan  
P.O. BOX 5240  
Kingston, NY 12402**

- **Claim Submission Tool for Medical Professional claims (CMS-1500) on our UnitedHealthcare Provider Portal (formerly Link)**
- **Behavioral Health Professional claims (CMS-1500) on our Provider Express Portal**

# Claim Submission

Claim tips can be found by clicking Admin Resources on the Provider Express – Indiana page

- Claims Problem Resolution
- Claim Submission Hints
- Outpatient Claims
- Training



The screenshot shows the Optum Provider Express website interface. At the top left is the Optum logo and the text "OPTUM® Provider Express". At the top right are links for "Log In", "First-time User", "Global", and "Site Map", along with a search bar containing the word "Search" and a "Search" button. Below this is a dark navigation bar with the following menu items: "Home", "Our Network", "Clinical Resources", "Admin Resources" (circled in red), "Video Channel", "Training", "About Us", and "Contact Us". Below the navigation bar is a breadcrumb trail: "Optum - Provider Express Home > Our Network > State-Specific Provider Information > Welcome Indiana". The main content area features the heading "Welcome to the Optum Network!" in orange, with two links below it: "Optum Network Manual" and "Indiana Medicaid-Specific Resources".



# Claim Submission Tips

- All clinicians should submit valid ICD-10CM Mental Health/Substance Abuse primary diagnosis code and encourages you to list all secondary diagnoses as clinically appropriate.
- Annually update Coordination of Benefits by calling United Behavioral Health at 877-610-9785.
- Verify that claims are submitted with the Place of Service code that matches the level of care provided.



## Claim Submission Tips continued

- For Observation claims - Outpatient Place of Service code should be used whenever observation bed level of care lasts less than 24 hours and results in a discharge to a less restrictive level of care.
- Verify the claim is sent to the correct mail address OR Payer ID if submitting electronically.
- If you have claim issues, call Claims Customer Service phone number 800-888-2998 to reach Optum Behavioral Health.
- Ensure that appeals are sent to the Care Advocate Center that issued the Adverse Benefit Determination.
- Update Provider Demographic information online through the Provider Express portal – “My Practice Info.”



# Training Items

- Training
  - Behavioral Health Tool Kits
- Guided Tours
  - Claim Entry
  - Claim Inquiry and Claim Adjustment Request
  - Overview of Filing COB and Corrected Claims

**OPTUM**® Provider Express

Home Our Network Clinical Resources Admin Resources

[Optum - Provider Express Home](#) > Training

### Training

- [Webinars/Training Resources](#)
- [My Practice Info Navigation for Groups](#)
- [Behavioral Health Tool Kits](#)
- ReviewOnline: Training resources are available within ReviewOnline.  
[Log In](#) > ReviewOnline > "Training Materials"
- [New Authorization Request Option \(known as STAR\) is available in Review Online](#)
- [Veterans Affairs Community Care Network \(VA CCN\) Resources](#)

### Guided Tours

- [ALERT](#)
- [Auth Inquiry](#)
- [Claim Entry](#)
- [Claim Inquiry and Claim Adjustment Request](#)
- [Contact Us](#)
- [Eligibility & Benefits](#) Updated Dec. 2019
- [First-time Users](#) registering on Provider Express
- [My Practice Info](#) for individual providers
- [Overview of Filing COB and Corrected Claims](#)
- Message Center
  - [Message Center Guided Tour](#)
  - [Message Center FAQs](#)
- [Provider Express Technical Guide](#)



# Claim Problem Resolution

Typically, there are two types of claim issues:

1. The claim was submitted with incorrect/inaccurate information
2. The claim was processed incorrectly

To resolve type 1:

- Submit corrected claims electronically through [Provider Express – Indiana](#)
- Complete a new CMS-1500 claim form and write “CORRECTED CLAIM” across the top and submit with the correct claim information and mail to the address on the statement

To resolve type 2:

- Login to Provider Express and look up the claim via Claim Inquiry transaction and file a Claim Adjustment Request.
- Contact a claims representative via Provider Express’ Live Chat
  - Locate the claim from the claim detail page then click “Have questions about claim status?” to access Claims Live Chat
  - Call the Customer Service number on the back of the member’s card or on the Explanation of Benefits/Provider Remittance Advice



# How do I Submit a Claim Reconsideration?

Securely login to Provider Express

- Claim Inquiry
- Search for claim
- Click “Enter” under claim adjustment

Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration.

The screenshot shows the Provider Express website interface. At the top, a navigation bar includes links for Home, Eligibility & Benefits, Auth Request, Auth Inquiry, Claim Entry, **Claim Inquiry EPR** (circled in red), ALERT, Provider Reports, My Provider Express, My Practice Info, Message Center, and Contact Us. Below the navigation bar, a red message states "Claim Inquiry\* - indicates required field(s)". A link "Click here to register for or view Electronic Payments and Statements" is visible. A search section titled "My Patients" includes tabs for "Member ID Search" and "Name/DOB Search". A form prompts the user to "Please complete the form below and click 'Search'", with a red note "- requires a required field". The form fields include Member ID, Group ID, and First Name. Below these are radio button options for "Optional - Dates of Service (defaults to 180 days before today's date)": "Month and Year", "Date Range (180 day limit)", "Previous 12 Months", and "Previous 24 Months". A grey box contains a recommendation: "Provider Express recommends using the minimum search criteria of Member ID and First Name only. Do not enter a group number unless the system prompts you via a specific message." A "Search" button is at the bottom right of the form.

**Claim Detail**

Date(s) of Service:	11/11/2015	Date Paid:	11/14/2015				
Clinician Name:	Provider, John Q.	Check #:	0				
Authorization #:							
Payee Name:	John Q Provider	Claim #:	X0987654321				
Address:	123 Main Street Anywhere USA 55555	Place Of Service:	OFFICE				
		Service Code:	90834HJ				
Claimed Amount:	Contract Rate:	Deductible Amount:	PT Responsibility:	Disallowed Amount:	Paid Amount:	Claim Status:	Claim Adjustment:
\$80.00	\$80.00	\$0.00	\$0.00	\$0.00	\$60.00	Finalized	<b>Enter</b>

Explanation:

Optum follows the prompt payment regulations applicable to each state and payments on finalized claims will be paid within these timeframes. Please be aware that some customers have asked to have payments made in batches, releasing payment for a number of clinician claims at specified intervals rather than as each claim is received and processed. The claim status detail will be updated with Paid Date, Check Number and other claim details once a payment has been released. If you have additional questions about this claim, please contact Optum at the toll-free number located on the member's ID card.

Navigation buttons: Previous Page, Summary Page, New Inquiry



# Submitting a Claim Reconsideration

- ✓ Select a reason from the dropdown.
- ✓ Select “Review.”
- ✓ Review details and add necessary comments on next screen.
- ✓ Select “Submit”.
- ✓ Once Submitted, document the “Confirmation Number” and “Issue ID”.

**Claim Adjustment - Entry**

After a claim has been processed, you may make a Claim Adjustment request. If you believe that a claim was processed incorrectly, please select a Reason from the list below. In addition, please include any information that should be evaluated in the claim adjudication process.

**Member Name** MEMBER NAME **Member Id** XXXXX0000-00  
**Clinician Name** Provider, John Q.

Date(s) of Service	Date Paid	Claimed Amount	Copay Amount	Disallowed Amount	Paid Amount
11/11/2015	11/14/2015	\$60.00	\$60.00		\$0.00

**Reason**

**Comment** CCB Adjustment

**Claim**   
respt of

255 characters left

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**Member Name** MEMBER NAME **Member Id** XXXXX0000-00  
**Clinician Name** Provider, John Q.

Date(s) of Service	Date Paid	Claimed Amount	Copay Amount
11/11/2015	11/14/2015	\$60.00	\$60.00

**Confirmation Number:** 500000005  
**Issue Id:** C21911807314774  
**Reason:** Incorrect Member Liability

**Comments:**  
Claim processed against member deductible, which was met on 10/31/2015. Please reprocess and pay.



# What if I don't agree with the outcome of my Claim Reconsideration?

- If you disagree with the outcome of your Claim Reconsideration, please contact your Indiana Behavioral Advocate.



# What is the next step in the Dispute Process?

- If you still disagree with the outcome of your claim after the Advocate team has escalated, your next step is to file a formal dispute.
  - Must be submitted within 60 calendar days from the failed reconsideration
- Mail to:
  - UnitedHealthcare Community Plan of Indiana,  
Attn: Appeals and Grievances Unit  
PO Box 31364  
Salt Lake City, UT 84131-0364
- Submit within Claims on our UnitedHealthcare Provider Portal



# What if I still disagree?

- If you still disagree with the outcome of your formal dispute, you may file a Formal Provider Grievance.

- Must be submitted within 120 calendar days from the failed Dispute (Must include additional or new information).

- Submit electronically within Claims on the UnitedHealthcare Provider Portal.

- **Mail to:**

UnitedHealthcare Community Plan of Indiana  
Attn: Appeals and Grievances Unit  
PO Box 31364  
Salt Lake City, UT 84131-0364



# Telehealth

- Updated 7/21/2022 - [Telehealth Services Codes \(indianamedicaid.com\)](https://indianamedicaid.com) → Updated telehealth Services code set
- 5/19/2022 - [BT202239 \(indianamedicaid.com\)](https://indianamedicaid.com) → BT202239 added additional codes that went into effect 7/21/2022.
- 6/30/2022 - [BT202249 \(indianamedicaid.com\)](https://indianamedicaid.com) → BT202249 added ABA codes as well as H0038 for Peer Support that allows for audio only with a 93 modifier.





# Questions and Answers